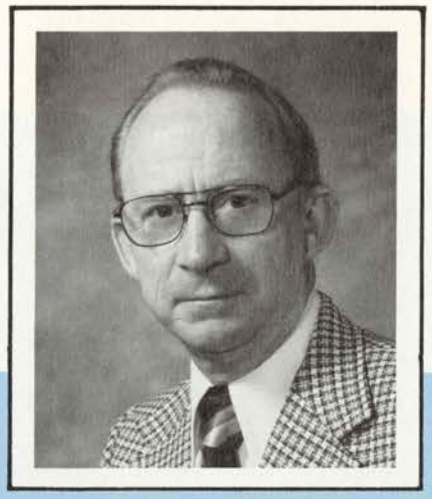
1978 BLUE SHIELD of FLORIDA, Inc. ANNUAL REPORT

Annual Meeting May 24, 1979
for the year ending December 31, 1978



Joseph G. Matthews, M.D.
Chairman of the Board

Message from the Chairman of the Board

1978 was a much better year for Blue Shield of Florida, and our Annual Report for this period of time will show that, indeed, we are in a much better financial posture than we were last year and the year before. Our claims processing performance, both in Medicare Part B and in our private business, is vastly improved this year . . . our public image and our professional relations continue to improve. Unfortunately, our administrative costs are higher than we should accept and efforts are continuing to bring these costs down to an acceptable level without sacrificing service. We have problems in the marketplace that are challenging us to innovate, to introduce new marketing procedures and to write new lines of business.

1978 was the final year of Jack Herbert's service as President of Blue Cross and Blue Shield, and represented the end of thirty-three years of service to the Blues. It was obvious to all concerned that Jack Herbert would be a difficult man to replace and a great deal of time, effort and study was made by committees of both Boards and a professional search firm to find that right man. This search process did not limit itself to looking inside of our own house, nor confine the search to Blue Shield executives from around the country, nor was the search limited to just insurance company executives. . . . After many letters had been written, many meetings, and many interviews, the final selection by both Boards was Mr. William E. Flaherty, the President of the Delaware Blue Cross/Blue Shield Plan. In a few moments you will meet Mr. Flaherty and hear his report.

The Federal Trade Commission Investigation

The Federal Trade Commission continues, in 1978, to investigate some of the Blue Shield Plans across the country, and Blue Shield of Florida was one of them. We have provided the commission all of the information and statistics that were requested, including the minutes of Blue Shield Board of Directors' meetings for several years. I feel that one of the reasons we were selected to be investigated was because we have a slight doctor majority on our Board of Directors — thirteen out of twenty-two are medical doctors. Congressional committees, the news columnists, and indeed, even

Secretary Califano has accused those Blue Shield Plans that have doctor majorities on their boards of having a **potential** conflict of interest. The innuendo is that the Board of Directors serves as a fee-setting body, and therefore has the power, and presumably exercises that power, to regulate the fees that doctors are paid for medical services under Medicare B and other government subsidized programs. I am confident that our records will clearly show that our Board of Directors, even though a doctor majority, does not in fact spend its time setting doctors' fees and, indeed, the minutes of the Board's meetings reflect that the Board of Directors serves the people of Florida, and that they are not playing the role of Provider Advocate. Recently, Secretary Califano did issue a "letter of intent" to probably discontinue contracting with insurers that have Provider majorities on the Boards. Eventually, Blue Shield of Florida may be forced to alter the ratio of doctors versus non-doctors on its Board, just as Blue Cross did several years ago when it voluntarily changed the ratio of hospital administrators to laymen on its Board.

The Relationship of Blue Shield to the Florida Medical Association

Thirty-three years ago, when Blue Shield was being born, the Florida Medical Association was not the founder, and as a matter of fact, the Board of Governors at that time was not in complete agreement over the birth. There were no F.M.A. dollars contributed to that initial twenty thousand dollars start-up fund, which was required by statute. That money came from contributions by physicians throughout the state and was later repaid by Blue Shield. Over the years, F.M.A. and Blue Shield have enjoyed a rather harmonious relationship, and 92% of the practicing physicians in this state are voluntarily contracting with Blue Shield as Participating Physicians.

The F.M.A. House of Delegates makes up a most significant part of the Corporate membership of Blue Shield and has the duty of electing the Board of Directors. The Board, in turn, is designated as the sole policy-making body. When appropriate, prior to making its decisions the Board seeks input from many sources. Over the years, the Board has received advice and recommendations from organized medicine, but cannot, and must not accept policy directives from the F.M.A. Board of Governors. The Blue Shield Board members serve a public trust. They do not serve for the benefit of any special interest group, any specialty, any geographic location. They do serve the Plan's subscribers, Medicare beneficiaries, physicians and the general public.

Unfortunately, a few doctors in organized medicine are under the impression that Blue Shield policies and decisions can be influenced or swayed by threats. In 1978, there was a suggestion that Florida Medical Association's "support" of Blue Shield be terminated if Blue Shield was forced to do certain things, such as instituting specialty screens in Medicare B or disclosing Physicians' earnings under the Medicare B program. . . . How would it have looked to the public, to our patients, to the government, to the headline writers, if the Florida Medical Association had indeed forced Blue Shield to drop its contract to serve the Medicare patients?

Medicare B Performance

As previously reported at these Annual Meetings, Blue Shield's performance in handling claims under the Medicare B program in the early and mid-

70's, was at times relatively poor. Then we reported that due to the installation of very sophisticated and high capacity equipment, Blue Shield's performance record had dramatically improved, and today can be compared with the tops in the country. In the nine southeastern states within our designated region, we at this time are enjoying an enviable record, and without reading long lists of boring figures, I would like to simply say that we are receiving over 600,000 claims a month; over 92% of the claims in December were processed within the first fifteen days, and our mean processing time fluctuates between five and six days. We have been able to reduce the number of personnel, as well as dramatically cut down the overtime hours, and the unit cost per claim is below the national average. These fine performance figures occurred in spite of the fact that about two-thirds of the doctors do not accept assignments. There are several reasons which make it possible to have such a fine record, even on unassigned claims. One is that we are getting excellent cooperation from most all of the doctors in the state in coding their claims for their patients. Back in 1975, only about 4% of the doctors in the state were pre-coding claim forms. Now, approximately 80% of the claims are coming in pre-coded in the doctors' offices.

Our Financial Position

In a few minutes you will hear a more detailed report regarding our financial position, but I feel I should briefly mention that two years ago this corporation was in a serious financial position, and for a while we were paying out more in claims than we were receiving in premiums, and we were experencing at the same time difficulties in getting adequate and timely rate increases from the Insurance Department. On two occasions we were forced to negotiate $3,000,000 loans from Blue Cross, and I am happy to report at this time that we repaid over half of the $6,000,000 and probably in the near future the total will be repaid.

Second Surgical Opinions for Elective Surgery

As everyone who reads the newspapers knows, there is at this point in time a great deal of conversation regarding the subject of second opinions, particularly second opinions as they relate to surgical procedures. Blue Shield of Florida in one of its major national accounts (specifically for the Southern Bell Telephone Company), has put into effect a second surgical opinion program. This is a non-mandatory, patient-initiated program to be used in elective or non-emergency surgical cases. It permits usual and customary reimbursement for the second surgeon's opinion and in no way is binding to the patient, nor does it cost the patient any more money. It even permits the payment of a third surgical opinion if the first two don't agree and the patient so requests.

We, at Blue Shield, feel that this is a program for the benefit of the patient which will permit the patients a certain amount of peace of mind in knowing that they have the benefit of more than one opinion, but we do not feel that this is a program that will save a lot of money by avoiding surgery. We do not at this time have enough statistics to give an accurate report about the trends in this program, other than to say there is very little utilization by Southern Bell employees.

The Department of H.E.W. has also put in a second opinion program for surgery, and Blue Shield of Florida, as fiscal intermediary for the State of Florida except Dade and Monroe Counties, and G.H.I., the intermediary for those counties, are the **list holders** for this program. Again, we have no good statistics to present at this time, for it will only be after a long period of experience, that conclusions can be drawn that would be valid, so the only comment again that we could make is that there is very little utilization.

Specialty Screens

Blue Shield of Florida, both in its private business and in its government business, continues to reimburse physicians in a uniform manner. We do not have a differential of payment to specialists compared to non-specialists. It is true that many Plans, and indeed, a majority of the Plans around the country administering the Medicare program, do have differentials of payment which are handled by specialty screens in the computers that determine allowances. There has in the past, been a moderate amount of pressure placed on us and on the government to change this in Florida, and indeed, this subject has been a hotly argued one in many places. It appears to me that this is probably a dead issue, and rumors that are coming down from Washington suggest that specialty screens will be eventually phased out nationwide.

What Is Ahead?

These two corporations, Blue Cross and Blue Shield, still face many challenges, and even though we occupy the "number one position" as a health care provider in this state, we still are being challenged and threatened by many factors, including our competitors. In order for us to continue to carry out our goals and pledge to the people of Florida, we must continue to be adaptive, to be innovative, and to seek better ways of providing our services to the public. We are studying the concepts of H.M.O.'s and A.S.O.'s (Administrative Services Only), and dental coverages. We should also be studying the pros and cons of merging the two corporations, as has been done in many Plans around the country. . . . In reality, Blue Cross and Blue Shield of Florida are merged in many aspects at the present time. Many of our administrative activities are completely merged, but we do still have separate Boards, separate financial structures, separate investment portfolios, separate contracts with providers. Having two separate organizations carries with it some strong disadvantages, particularly in dealing with purchasers of coverage who view us as one organization.

We will also have to be looking at our Board composition. We may very well be forced by statute to change our Board composition so that there will be consumer or layman majority on our Board. It may be more to our advantage to rearrange this voluntarily than to have it thrust upon us by governmental decree. This is exactly the same problem that faced Blue Cross several years ago when there was a majority of hospital administrators on that Board.

This coming year we may have to look closely at the existing structure of our relationship with the Florida Medical Association, and there is a possibility that the composition of the corporate membership of Blue Shield of Florida will be changed.

I feel that Blue Shield this year has continued to improve in all departments. We are in a much more stable position than we have been for years, not only financially, but in our position of respect in the eyes of those that we serve. I would like to again thank all of our Board members who unselfishly dedicate their time, their talent, and their wisdom to this fine corporation, and to the people of Florida that we serve.

I would like also personally to thank Joe Stansell, our Senior Vice President, for his outstanding work and his devotion and loyalty to Blue Cross and Blue Shield. I would like also to again compliment and thank Dan Lewis, the Senior Vice President of Benefits Administration. Dan and his team are responsible for the spectacular improvement in our claims processing which, in the case of Medicare B, puts us in a position of being one of the most efficient claims processors in the country.

I would also like to recognize and salute Jack Herbert, who actually was our chief executive officer from 1970-1978, and to thank him, not only for his work as our President and leader for these many, many years, but also for the contribution that he has made to the Blue Cross and Blue Shield Plans nationwide. We are not saying good-bye to Jack Herbert today, for he will continue to be with us. He has been elected unanimously to serve as an Honorary Board member for both corporations.

I would like to again thank our Secretary to the two Boards, Edwina Thornton, who has served this Board in this capacity for thirty-three years.

William E. Flaherty
President

President's Message

It is a pleasure to be with you at this meeting in the capacity of President of Blue Shield of Florida. Being new to Florida I can't help but wonder if you are aware of the high visibility of Florida physicians and the Florida Blue Shield Plan nationally. If you are not, let me assure you that I am, and that is one of the reasons I am excited to be here and to "get at" the challenges that we face in both the immediate present and the future. When I say "we" I am first referring to the close coordination that will go on between Dr. Matthews, the Chairman of the Board, and myself as programs are developed that are directed at the successful operation of a very large business that exists to help the people of Florida meet their health care needs.

Indivisible from my working with Dr. Matthews is the cooperative effort of the full Blue Shield Board as questions of policy or approval of major programs are required, as well as providing guidance to management based upon the knowledge and experience they have gained from their successes in their individual fields.

The Plan is confronted with hundreds of issues and requirements for changes. These range from new services by competitors to increasing legislative pressure to have government intervene further by setting hospital rates and evaluating usage. Our success depends upon timely coordinated efforts by a dedicated and competent management and staff.

As president, one of my first interests is to develop the policy guidelines and financial plans which are needed for a coordinated effort. Using private industry's definition, these refer to the corporate purpose, objectives and budgets. When this corporate purpose has been developed it will have been created through the joint effort of our executive staff, and it will have received the careful review of the appropriate committees and the Board.

Needless to say, planning and operating budgets then are top management priorities and they will receive very extensive attention in the immediate future.

The challenges I mention are national in scope, not just in Florida, and they make essential new levels of teamwork to offset the trends we see before us.

Doctors and Blue Shield

Dr. Matthews has already reported on the activity which took place in 1978 relative to the ongoing relationship between Blue Shield and the Florida Medical Association. Consequently, I will not touch on that except to state that it is my position that when there are two organizations as important to the future of a voluntary system for health care as the Florida Medical Association and Blue Shield of Florida . . . such review of our responsibilities and relationships is essential.

An intelligent and objective appraisal of our role and structure is a necessary action. These relationships are changing all around the country and Florida Blue Shield will need an efficient and effective structure plus the understanding and support of both the public and physicians if it is to survive in a competitive market.

F.T.C. and Other Regulatory Actions

At the federal government level there has been a strong initiative for several years to increase competition within the professions, including medicine. Also, an atmosphere of increased regulation reflects concerns over rising health care costs. While many factors have influenced costs including new technology, general inflation and consumer demand for more services, there is a push for regulation to strengthen competition and separate buyers and sellers. This is occurring despite joint efforts for the common good. As an example, interlocking directorates for private profit-making corporations in some industries are now prohibited as restricting competition. Also, with increased concerns over costs there are initiatives to prohibit both the appearances as well as the actual arrangements which restrict competition.

I feel I need to report to you the current status of two primary regulatory actions from Washington directed at the doctor/Blue Shield relationship. First, let me touch on H.E.W.'s proposed regulation affecting health insurers that reimburse doctors under the Medicare program. This originally affected thirty-two Blue Shield Plans with Medicare responsibilities such as we have in this state. Under this proposed regulation, Medicare contractors will be required to assure that a majority of the members of their Boards and key committees have no direct or indirect financial interest in the delivery of health care services. As of this writing no further developments have been announced by H.E.W. Secretary, Joseph Califano, but we expect to be dealing with this issue before long.

At our March Blue Shield Board Meeting the Board of Directors was advised that although Florida Blue Shield had been served a subpoena last spring by the Federal Trade Commission for information covering various aspects of our operation, no formal action has yet been taken on this issue by the F.T.C. The concern of the Bureau of Competition of the F.T.C. is that a dominance by physicians and other health care providers of Blue Shield Boards has an adverse impact on the cost of health services or health insurance. The recent U.S. Supreme Court decision in the Royal Drug Case has removed to some degree an important basis for a Plan to claim it is exempt from the anti-trust regulatory arena.

Also in our dealing with the state legislature, Plan management is often questioned as to whether it can speak objectively for its subscribers and

members since it has a Board with a majority of physicians who provide the services we cover. This atmosphere appears to have been intensified by the current debate over hospital rate setting by state government, as well as by changes in Pennsylvania and Ohio in which two of the largest of the Blue Shield Plans have changed to a public majority on the Boards.

State and Federal Regulations for Maternity Benefits

Before moving off the subject of government activity I want to report two recent actions which have just been implemented on a state and federal level that are going to have a significant upward effect on health care coverage rates. A regulation from the State Insurance Department has made it mandatory that insurers offer optional maternity coverage under one person contracts whenever maternity is offered under family contracts. Blue Shield has to make this option available to both our Group and Direct Pay contract holders.

A recent federal law on maternity benefits is based on anti-discrimination because of sex, and makes it necessary for maternity related benefits for employees to be on the same basis as other benefits covered under the policy with respect to both the level of benefits and waiting periods. The Equal Employment Opportunity Commission says this applies to female spouses of employees as well. We are currently feeling the effect of these new requirements in the rewriting and distribution of our benefit literature and contracts, inasmuch as most current literature and contracts must be changed.

Uniform Claim Form

In 1977 the Florida legislature passed a law requiring providers to use a uniform claim form. Delay in getting the law implemented postponed our involvement until January of this year when at our January 20th Board Meeting it was reported that the Insurance Commissioner had recently issued an order indicating that all claims sent to Blue Shield, or any insurance company, must use the A.M.A. approved Health Insurance Claim Form (HICF) or one approved modification of the form. Florida physicians have been sent a statement from the Insurance Commissioner regarding the use of the new form and Blue Shield went on record that it would accept the HICF immediately, which will eventually make our Blue Shield claim form obsolete. We have not heard from the Insurance Department as to when the cut-off will be on the Blue Shield claim form, but no additional Blue Shield claim forms are being distributed.

The Physician Affairs Department

Blue Shield employees who deal most directly with physicians and medical assistants are those in our Physician Affairs Department. They number thirty-eight.

In 1978 Physician Affairs representatives made 10,952 calls to physicians' offices. 781 new physicians practicing medicine in the state were contacted with all but 29 becoming Participating Physicians.

Our two education-service representatives held 107 Medical Assistant Workshops, attended by 2,417 Medical Assistants. The statistic that most pleases us, however, is that in 1978 you increased the percent of claims coming in pre-coded to 80%. This refers to both Blue Shield private business and Medicare Part B claims and is a most meaningful measure of your cooperation in serving your patients, our subscribers and the Medicare beneficiaries.

Medical Necessity Program

In February, 1979, Florida Blue Shield in conjunction with action of the National Blue Cross and Blue Shield Association publicized the fact that it would no longer cover routine laboratory examinations in a hospital for surgical patients unless requested for a specific patient by his or her physician. This cost containment effort was an extension of the 1977 rulings, bringing to forty-two the number of surgical and laboratory procedures which would no longer be covered because they were felt to be either medically obsolete or wasteful when performed on a routine basis. I am pleased to report that eighteen months prior to this national cost containment measure we in Florida had instigated our own restrictions on battery testing on hospital admissions. The Claims Committee, seeing the unneeded expense of routine tests and laboratory procedures on both surgical and non-surgical admissions, suggested this be brought to the attention of the Blue Cross Board. This recommendation of the Blue Cross Insitutional Affairs Committee was adopted by the Blue Cross Board, and word was disseminated of this action to the medical profession through our newsletters. We are pleased that the medical profession has supported this cost containment effort with only a few expressions of concern by individual physicians using pre-printed orders. To them we have responded that such pre-printed orders are not acceptable unless they are capable of being individualized and countersigned by the physician . . . there are a few exceptions to this rule.

Health Maintenance Organizations

Statewide statistics from our existing group accounts and planning agencies show a continual growth of H.M.O.'s and a loss of Blue Shield membership to them.

Most of you are probably aware that Blue Shield developed in cooperation with the Jacksonville Area Foundation for Medical Care, an experimental H.M.O. program for our own employees, titled the Health Maintenance Program. After two years this pilot study was discontinued in August, 1978, due to a number of difficulties including heavy utilization that could not be supported by the rates charged. Recognizing there are many complex factors involved, both the Blue Shield and Blue Cross Boards have approved an intensive nine-month study by management into current H.M.O. activity and the potential of H.M.O.'s in Florida. This will include an evaluation of our possible involvement in this alternate delivery system through analysis of data on financial, marketing and physician attitudes, as well as legal aspects. This investigation has just begun.

Florida Committee on the Cost of Medical Care

Early in 1978 Blue Shield participated in the formation of the Florida Committee on the Cost of Medical Care, which is the Florida counterpart of the national "Voluntary Effort". This Florida Committee is made up of representatives of doctors, hospitals, Blue Cross and Blue Shield and commercial insurance companies. Its purpose is to develop a program of cost containment within the state that will be identified by the general public as a voluntary effort. In conjunction with this effort the Committee is to develop a program titled "Cost Awareness" for presentation to hospital medical staffs throughout the state. Blue Shield is playing an active role in this effort.

Report on Claim Payments

I am most pleased to report that Florida Blue Shield has shown such a marked improvement in its claim payment performance in both the private sector of business and with Medicare Part B.

In our private business Blue Shield Plans rate their effectiveness by performance standards which are derived from comparative studies of all the Plans' claim operations. Out of the twenty-three peer Plans that we are rated against, Florida Blue Shield has ranked second in standards of performance for the last two quarters of 1978. This is a far cry from the record Florida held a year ago, and I certainly give credit to those in the Plan who worked so diligently to improve our performance.

Of equal importance is the superior performance of our Medicare Part B operation, and I would like to briefly mention several of the areas of comparison:

FY 1978	Blue Shield of Florida	National Average
Work weeks on hand (claims)	.5	1.4
Unit cost per claim	$2.59	$2.86
Number of calendar days to process a claim	10.9	12.9
Percent of claims pending over 30 days	9.2	13.9

In a recent H.E.W. Annual Contractory Evaluation Review (ACER) all performance areas were rated **satisfactory** which is the highest quality rating a Plan can receive. Florida received this rating for the first time.

Marketing Report

Serious deterioration has continued, especially in our employer group market. Enrollment decreased by 116,641 members, bringing the number of

Floridians covered to 1,460,869 as of December 31, 1978. This rate of loss threatens the Plan's survival as a business. I can assure you, stopping this decline and turning this enrollment figure around to a positive climb toward a higher percentage of Floridians covered by Blue Shield and Blue Cross is a top priority.

While a comprehensive analysis of our marketing performance and problems is being initiated, two new coverages offered this past year should increase enrollment. They represent the offering of improved levels of benefits to individuals and small groups.

"Dimension III" offers individuals and families comprehensive, major medical type coverage with a realistic $200 deductible and 80/20% co-insurance. These features, plus the fact that the program is age rated should allow us to offer this coverage at a very competitive rate.

The Business Employers Trust (BET) gets us into the small group market more realistically than ever before. It brings with it such features as a high and low option comprehensive contract designed for groups with two to twenty-five employees. These individual groups are then combined to form a trust. Our initial offering of BET was well received by the small group market, and we anticipate a healthy growth in this segment of the market.

Organization Effectiveness

To obtain the overall improved corporate performance that is our objective, we must have qualified and motivated people working with the advanced technical skills used in American industry and managed by a professional management group. Considerable efforts will be spent on training and development over the next several years.

Plan Finances and Costs

As the enclosed schedule indicates the Plan's unallocated reserves increased by $8,943,156 in 1978, due primarily to rate increases and some lowering of utilization. However, these rate increases also contributed to the sharp loss in enrollment just reported. The net result has been to require reductions in staff. To date this has not yet been adequate.

With both a decline in private market sales and use of an outside subcontractor for our Medicare Part B claim processing, we have less processing volume over which to spread fixed costs and general expenses.

The current high operating costs require management to give immediate attention to increased efficiency and effectiveness in order to be competitive. While reducing these operating expenses we also need to spend more on "research and development" and "training and organizational development". A corporate budget and operating plan will be submitted to the Board in the fall and provide detailed information on these matters.

In Conclusion

Some of the information contained in this, my first President's message, has been most positive and a pleasure to report . . . such as the dynamic upward swing in our claims performance. However, as Dr. Matthews and I have both reported there are currents of activity that threaten the business survival of the Plan. While adherence to the old ways does not interest me, I voice my concern that we must redesign and renew ourselves to meet today's challenges. In doing this we must be careful to protect those strengths that we, Blue Shield and Participating Physicians, bring to the service of our community and the maintenance of the voluntary health care system. Our biggest resource remains our ability to communicate to each other and work together effectively . . . and to this end we direct our full attention.

Thank you, Jack Herbert, for what you have given the Plan in the past. Your cooperative attitude and thoughtful assistance has been most appreciated and has certainly been valuable to me in my first months as President of the Florida Plans. Likewise, the positive attitude of Dr. Matthews and the Board along with that of staff, has been most encouraging and I think indicative of the future of Blue Shield of Florida.

William E. Flaherty

Pertinent Statistical Information

Subscribers' fees earned
a 16 percent increase $134,898,509

Claims Incurred
a 7 percent increase $107,634,465

Enrollment decreased by 116,641 members bringing the number of Floridians covered to 1,460,869 as of December 31, 1978.

$23,230,000 in reserve at the end of 1978 for subscriber benefits.

$10,360,744 as the market value of our investments in bonds.

$3,583,148 as the market value of our stock.

MEDICARE PART "B" REPORT

The volume of Medicare Part "B" claims and payments as taken from the count of "SSA Monthly Intermediary Financial Report":

	1978	1977	
Volume	6,520,501	5,411,330	20.5% Increase
Payments	$348,935,662	$286,386,639	21.8% Increase
Other pertinent statistics are:			
Assignment Ratio	38.2	35.9	Florida
	53.7	54.0	Regional
	54.6	55.0	National
Work on hand as of Sept. 30 (expressed in weeks)	.5	.9	Florida
	1.1	1.4	Regional
	1.4	1.4	National

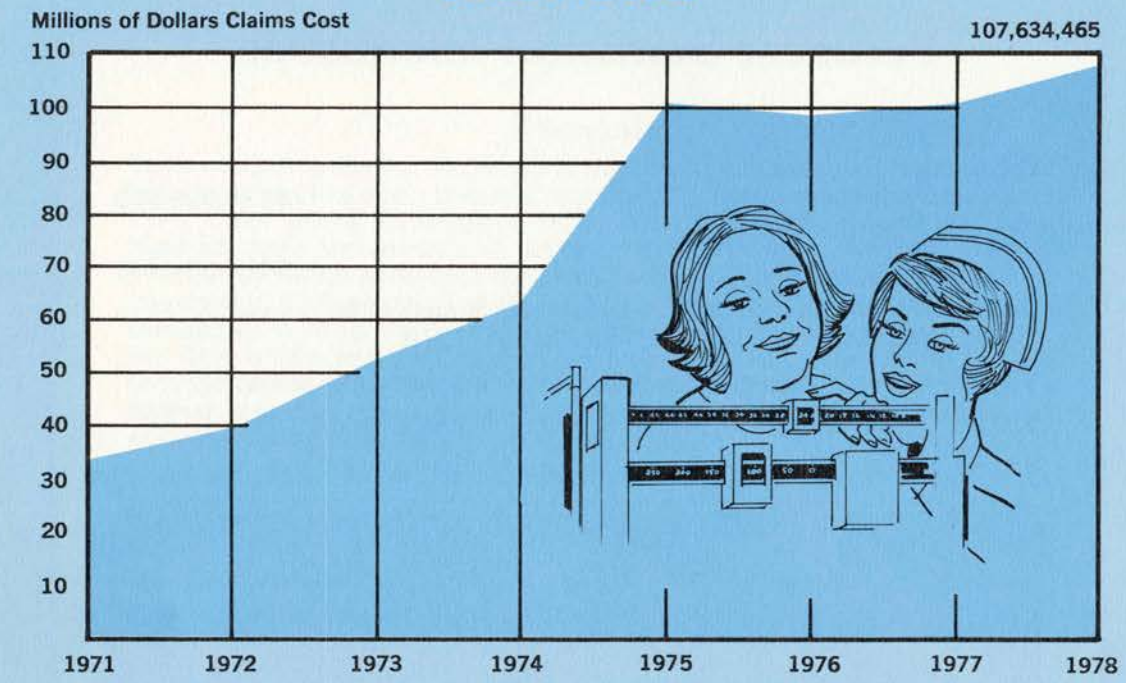
50,476 CHAMPUS claims were handled in 1978, a decrease of 186,784 from 1977.

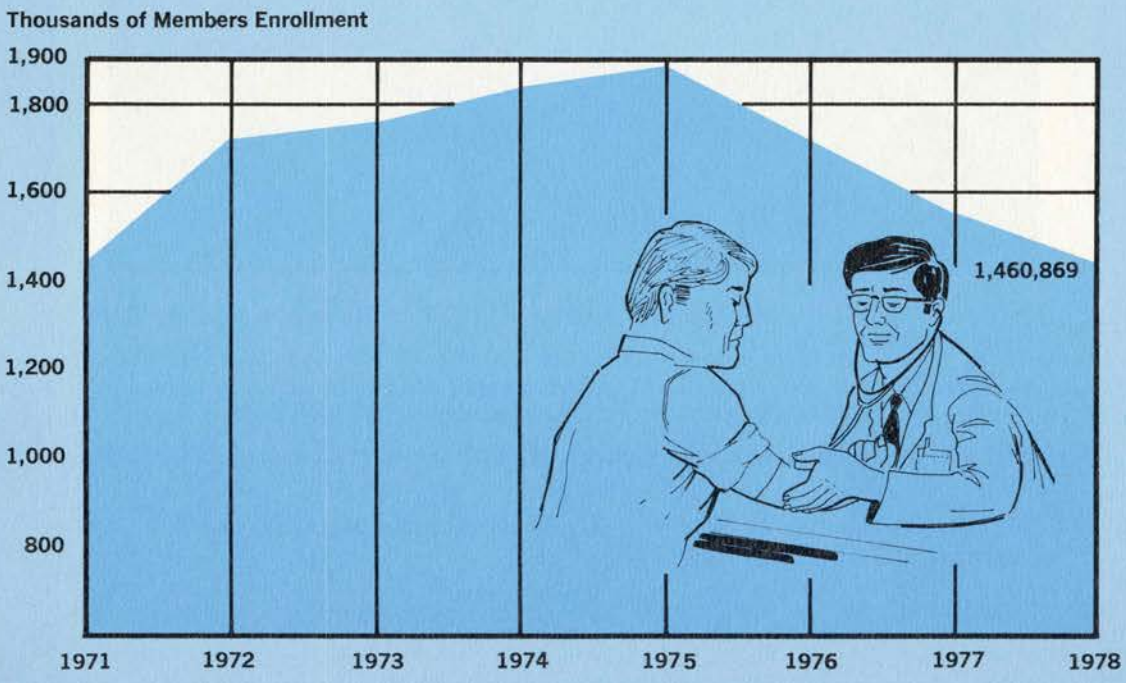
$3,920,774 was the amount of disbursements to Physicians for services rendered to CHAMPUS beneficiaries or a decrease of $13,663,606.

174,135 Medicaid claims were handled in 1978, a decrease of 310,479 from 1977.

$1,794,891 was the amount of disbursements under Medicaid in 1978, a decrease of $4,636,200 from 1977.

Comparison of Members Enrolled With Claim Costs





How Your Blue Shield Dollar Was Spent

Significant Comparisons
Between 1977 and 1978
Operations

1977

1978

Distribution of Blue Shield Benefits

Significant Comparisons
Between 1977 and 1978
Operations

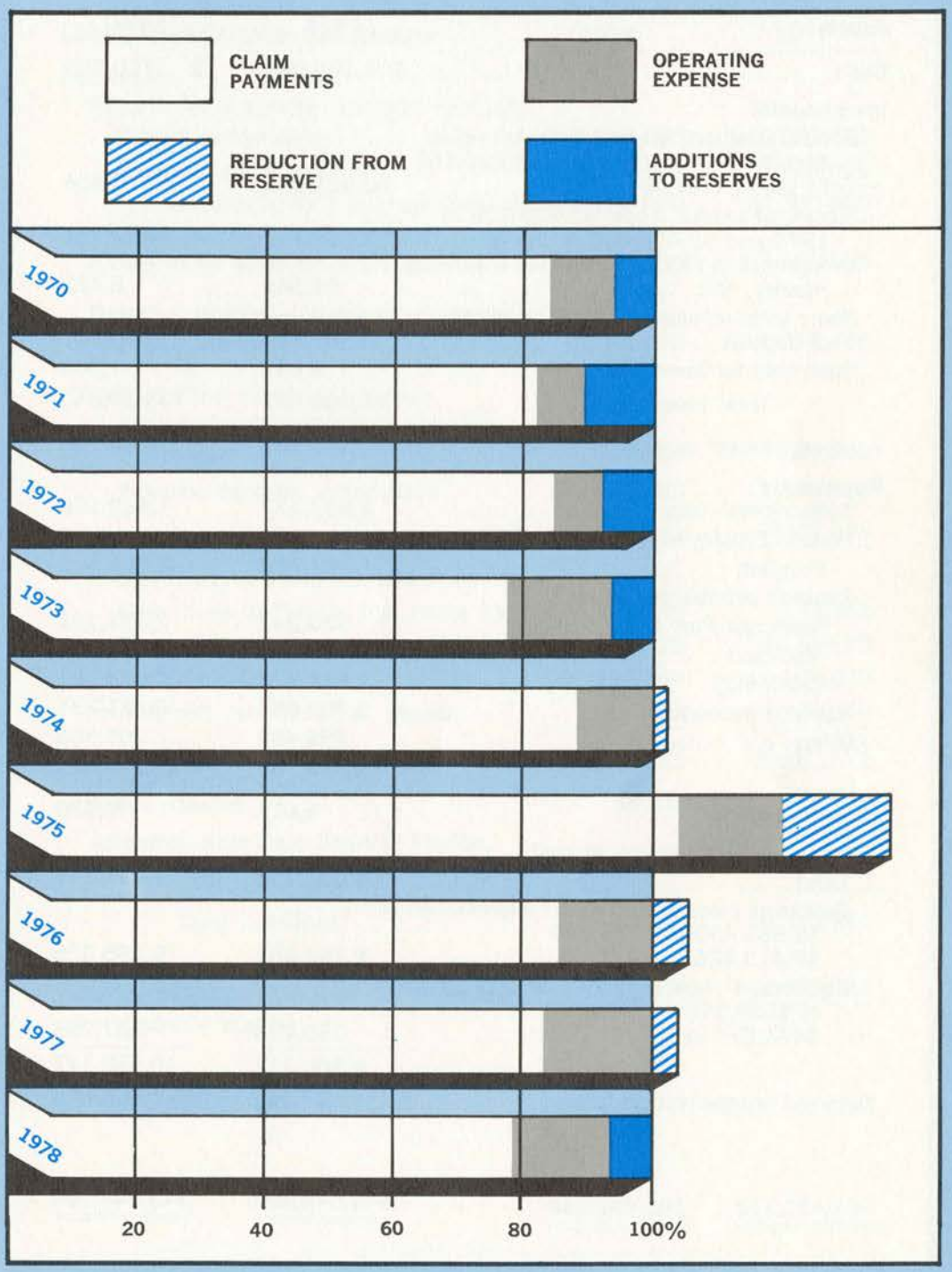
1977

INHOSPITAL MEDICAL 25.4¢
SURGERY NOT INPATIENT 8.2¢
DIAGNOSTIC AND THERAPEUTIC X-RAY 4.0¢
ANESTHESIA 7.0¢
OBSTETRICS 3.3¢
PATHOLOGY 3.6¢
SURGERY INPATIENT 37.8¢
PROFESSIONAL COMPONENT 9.9¢
PSYCHIATRIC CARE 0.8¢

1978

INHOSPITAL MEDICAL 28.6¢
SURGERY NOT INPATIENT 7.9¢
DIAGNOSTIC AND THERAPEUTIC X-RAY 4.4¢
ANESTHESIA 6.9¢
OBSTETRICS 2.9¢
PATHOLOGY 3.5¢
SURGERY INPATIENT 35.3¢
PROFESSIONAL COMPONENT 10.0¢
PSYCHIATRIC CARE 0.5¢

Distribution of Income – Year Ending December 31



Blue Shield of Florida, Inc.
Balance Sheets

December 31, 1978 and 1977

Assets	1978	1977
Cash	$ 1,105,596	$ 710,366
Investments:		
Bonds, at amortized cost (market value $10,360,744 in 1978 and $9,820,150 in 1977) (note 6)	10,921,902	10,116,404
Stocks, at market (cost $3,329,220 in 1978 and $3,464,030 in 1977)	3,583,148	3,434,851
Investment in Florida Combined Insurance Agency, Inc.	91,346	6,482
Short term investments and certificates of deposit	3,997,869	1,070,000
Cash held for investment	6,692	1,303
Total investments	18,600,957	14,629,040
Accrued interest receivable	269,357	200,355
Receivables:		
Subscribers' fees	2,207,177	1,989,150
Federal Employee Health Benefits Program	6,337,795	3,801,695
Expense reimbursements:		
Medicare Part B	530,242	2,237,121
Medicaid	550,241	378,865
CHAMPUS	1,856,173	2,024,121
National accounts	3,702,664	6,421,331
Other	295,490	205,538
	15,479,782	17,057,821
Prepaid expenses	6,611	8,930
Property and equipment, at cost:		
Land	1,060,798	1,060,798
Buildings (less accumulated depreciation of $2,862,430 in 1978 and $2,413,426 in 1977)	8,760,081	9,185,076
Equipment (less accumulated depreciation of $589,346 in 1978 and $441,675 in 1977)	159,238	307,253
	9,980,117	10,553,127
Deferred compensation funds	97,941	85,070
	$45,540,361	$43,244,709

Balance Sheets (Continued)

Liabilities and Unallocated Reserve	1978	1977
Liabilities:		
Reserve for subscriber benefits (note 2):		
Claims outstanding	$15,030,000	$17,022,000
Reimbursement contracts	8,200,000	7,278,000
Total reserve for subscriber benefits	23,230,000	24,300,000
Provision for experience rating refunds	2,289,096	7,162,085
Deferred income — subscribers' fees paid in advance	3,299,028	2,376,465
Deposits and advances payable:		
Federal Employees Health Benefits Program	332,100	371,800
Advance deposits, other plans	1,084,925	1,870,569
	1,417,025	2,242,369
Accounts payable and accrued expenses:		
Blue Cross of Florida, Inc. (note 3)	2,979,249	782,583
Creditors and accrued expenses	1,194,428	1,166,979
Accrued salaries	120,344	133,070
Deferred compensation payable	97,941	85,070
	4,391,962	2,167,702
Notes payable	49,236	75,230
Advances from Blue Cross of Florida, Inc. (note 4)	3,000,000	6,000,000
Total liabilities	37,676,347	44,323,851
Unallocated reserve (deficit) (notes 4 and 8)	7,864,014	(1,079,142)
Commitments (note 7 and 9)		
	$45,540,361	$43,244,709

Statements of Operations and Unallocated Reserve

Years ended December 31, 1978 and 1977

	1978	1977
Subscribers' fees earned (note 5)	$134,898,509	116,476,299
Claims incurred	107,634,465	100,431,051
Operating expenses (notes 6 and 7)	20,159,358	17,997,052
Total claims incurred and operating expenses	127,793,823	118,428,103
Gain (loss) from operations	7,104,686	(1,951,804)
Other income (losses):		
Investment and other income	1,733,835	989,195
Realized investment losses	(263,336)	(268,717)
Equity in net earnings (losses) of Florida Combined Insurance Agency, Inc.	84,864	(80,151)
Total other income	1,555,363	640,327
Net income (loss)	8,660,049	(1,311,477)
Unallocated reserve (deficit) excluding net unrealized investment gains (losses):		
Balance at beginning of year	(1,049,963)	261,514
Balance at end of year	7,610,086	(1,049,963)
Net unrealized investment gains (losses):		
Balance at beginning of year	(29,179)	107,519
Decrease (increase) in net unrealized investment losses	283,107	(136,698)
Balance at end of year	253,928	(29,179)
Unallocated reserve (deficit) balance at end of the year	$ 7,864,014	(1,079,142)

See accompanying notes to financial statements.

Statements of Changes in Financial Position

Years ended December 31, 1978 and 1977

	1978	1977
Funds provided from (required for) operations:		
Net income (loss) transferred to unallocated reserve	$8,660,049	(1,311,477)
Charges (credits) to operations not requiring funds:		
Increase (decrease) in certain liabilities:		
Reserve for subscriber benefits	(1,070,000)	(1,729,285)
Provisions for experience rating refunds	(4,872,989)	6,200,943
Deferred income — subscribers' fees paid in advance	922,563	(406,106)
Accounts payable and accrued expenses	2,224,260	(1,790,463)
Decrease (increase) in certain assets:		
Subscribers' fees and other receivables	1,509,037	(4,171,214)
Investment in Florida Combined Insurance Agency, Inc.	(84,864)	80,151
Depreciation	937,520	838,005
Amortization of bond discount, net	(44,974)	(16,038)
Funds provided from (required for) operations	8,180,602	(2,305,484)
Other funds provided (used):		
Investments:		
Sales:		
Bonds, long-term	7,084,752	3,681,347
Stocks	1,472,244	1,379,551
Short-term investments	45,000	—
Purchases:		
Bonds, long-term	(7,845,276)	(4,371,411)
Bonds, short-term, net	(2,972,869)	(479,056)
Stocks	(1,337,434)	(1,745,545)
Sale (purchase) of property and equipment, net	(364,510)	23,850
Deposits and advances payable	(825,344)	214,326
Advances from Blue Cross of Florida, Inc.	(3,000,000)	3,000,000
Deferred compensation funds and prepaid expenses	(10,552)	(12,399)
Notes payable	(25,994)	55,190
Increase (decrease) in cash and cash held for investment	$ 400,619	(559,631)

See accompanying notes to financial statements.

Notes to Financial Statements

December 31, 1978 and 1977

(1) Summary of Significant Accounting Policies

Blue Shield of Florida, Inc. (the "Plan") is incorporated as a non-profit corporation in the State of Florida and is subject to regulation by the Insurance Department of the State of Florida. Medical and other health benefits are provided under contract with subscribers through physicians. The Plan also performs administrative services such as billing, collection and promotion for Blue Cross of Florida, Inc. ("Blue Cross") and processes claims for other Blue Shield plans' subscribers and for programs such as Medicare, Medicaid, CHAMPUS, and the Federal Employees Health Benefits Program ("FEP"). The Plan and Blue Cross have formed joint programs to provide major medical, comprehensive and complementary coverages to subscribers.

The Plan and Blue Cross are members of the Blue Shield Association ("BSA") and Blue Cross Association ("BCA"), respectively, which are national associations. These organizations establish national policies and set standards for the programs.

The statutory financial statements of the Plan which are filed with the State Insurance Department have been adjusted to conform with generally acceped accounting principles (GAAP). The major accounting principles and practices followed by the Plan are presented below to assist the reader in evaluating the accompanying financial statements and notes.

(a) Investments

Bonds are carried at amortized cost adjusted where appropriate for amortization of premium and discount. No provision has been made for the excess of cost over market value of bonds since the Plan generally intends to hold such investments to maturity and does not expect to realize any significant losses.

Common and preferred stocks are carried at market value. Net unrealized gains at December 31, 1978 consist of gross unrealized gains of $390,805 and gross unrealized losses of $136,877.

Realized investment gains and losses are calculated on the basis of specific identification at the time investment securities are sold.

Florida Combined Insurance Agency, Inc. (the "Agency") is jointly-owned by the Plan and Blue Cross. Each Plan owns 50% of the number of shares outstanding. The Agency acts as an agent or broker when group life, accident, or disability insurance is sold as a package with the Plan's health coverages. Investment in the Agency is accounted for using the equity method.

(b) Subscribers' Fees Earned

Subscribers' premiums are billed in advance of their respective coverage periods. Receivables and income are recorded for

the unpaid earned portion of the billings. The unearned portion of premiums paid by subscribers is recorded as deferred income and transferred to subscribers' fees as earned.

Subscribers' fees earned by both plans are divided pro rata based upon claims cost and administrative expenses incurred by each plan.

(c) **Property and Equipment**

Land and buildings, used mutually with Blue Cross, are owned jointly by the two Plans. Property and equipment are recorded at cost, which includes expenditures for significant improvements. Maintenance, repairs and minor improvements are expensed as incurred. When fixed assets are retired or otherwise disposed of, cost and accumulated depreciation are removed from the accounts and any resulting gain or loss is reflected as other income. Depreciation is computed on the straight-line method over the estimated useful lives which range from two to fifty years.

(d) **Reserve for Subscriber Benefits**

The Plan provides for incurred, incomplete and unreported subscriber claims based on historical paid claims data and experience using an actuarially accepted statistical method. Processing expenses related to such claims are accounted for as paid.

(e) **Provision for Experience Rating Refunds**

Under certain group contracts, the Plan's income (retention fee) is limited to a predetermined percentage of either total subscriber fees or incurred claims. Any excess of subscriber fees over incurred claims plus retention fees accrues to the policyholder. Depending on the terms of the contract, such excess may be refunded in cash or utilized to increase benefits or reduce subscribers' fees in subsequent periods.

(f) **Expense Reimbursements**

Operating expenses are allocated by various lines of business in order to determine the expense reimbursements due from Medicare, where the Plan acts as a fiscal intermediary, and also from other Blue Shield plans and other Federal and State health programs for which the Plan processes claims. Expense reimbursements are also calculated for operating expenses incurred on behalf of Blue Cross, certain health maintenance organizations and the major medical joint program. The method by which the Plan is reimbursed is either actual costs incurred or amounts based on predetermined budgets and pursuant to industry practice are offset against operating expenses in the accompanying financial statements.

(g) **Pension Plan**

Pension expense includes amortization of prior service costs over a period of fifteen years. The Plan's policy is to fund

pension costs accrued which are composed of normal costs and amortization of prior service costs.

(h) **Income Taxes**

The Plan is exempt from both Federal and State income taxes.

(i) **Reclassifications**

Certain amounts in 1977 have been reclassified to conform with presentations adopted in 1978.

(2) Reserve for Subscriber Benefits

The reserve for subscriber benefits provides for incurred, incomplete and unreported claims and is calculated using a projected pure premium developed by the regression line method. The estimated reserves relating to National, FEP and Cost Plus (reimbursement contracts) are also established as a receivable and thus have no effect on net income. The Plan receives administrative fees or expense reimbursement for these lines of business and is reimbursed for incurred claims.

During 1977, the Plans entered into a reinsurance agreement between Health Services, Inc. (HSI), wholly-owned by BCA, and Medical Indemnity of America, Inc. (MIA), wholly-owned by BSA. Under this agreement, HSI and MIA reinsure 100% of major medical coverage in excess of $25,000 up to $250,000 for all group certificates, conversion and transfer and direct pay subscribers.

(3) Note Payable

Included in the payables is a note payable to Blue Cross of Florida, Inc. of $207,600 representing the unpaid principal balance of a $2,076,000 promissory note dated January 1, 1970 for the purchase of an undivided one-half interest in the land and buildings. The note is due in quarterly installments of $51,900 plus interest at the average percentage yield of Blue Cross's security portfolio of the preceding year. The note payable matures December 31, 1979 and is collateralized by securities with a market value of approximately $410,000 at December 31, 1978.

(4) Advances from Blue Cross of Florida, Inc.

During 1976 and 1977, $6,000,000 in advances were made to the Plan from Blue Cross of Florida, Inc. These advances, consisting of two $3,000,000 surplus notes, were made to comply with requests of the Insurance Department of the State of Florida (the "Department") to increase the Plan's unallocated reserve. Repayment of the notes, including interest at the average percentage yield of the Blue Cross security portfolio of the preceding year but not to exceed 8%, may be made only to the extent that the Plan's statutory unallocated reserves exceeds $6,000,000 and upon advance approval of the Department. During December 1978, $3,000,000 plus interest of $569,048 was repaid. Interest expense accrued and unpaid as of December 31, 1978 is $12,826.

(5) Allocation of Subscribers' Fees Earned

Effective January 1, 1978, the Plan and Blue Cross entered into an agreement whereby subscriber fees earned by both corporations

are divided pro rata based upon claim costs and operating expenses incurred by each corporation. Under this agreement, which was approved by the Boards of Directors and the Insurance Department of the State of Florida, subscriber fees earned by the Plan and net income were increased by $1,972,000 for 1978. Had this agreement been in effect during 1977, it would have resulted in an increase of $2,373,000 in subscribers' fees earned and net income.

(6) Agency Contracts

The Plan serves as Part B Intermediary for the Medicare program and fiscal agent for certain services of the Medicaid and CHAMPUS programs. Claims are paid by draft on a depository and are not reflected in the general accounting records of the Plan. Effective April 1978 for the CHAMPUS program and June 1978 for the Medicaid program, the Plan does not serve as fiscal agent. A summary of the claims processed in 1978 and 1977 for the two programs follows:

	1978 (Unaudited)		1977 (Unaudited)	
	Number of claims	Benefits	Number of claims	Benefits
Medicare	6,520,501	$348,935,662	5,411,330	$286,386,639
Medicaid	174,135	1,794,891	484,614	6,431,091
CHAMPUS	50,476	3,920,774	237,260	17,584,380

Effective May 1, 1978, the Plan and Blue Cross entered into an agreement with the State of Florida whereby both Plans are acting as Administrator for the State of Florida — Employee Group Health Self-Insurance Plan. Claims are paid by draft on a local depository and are not reflected in the general accounting records of the Plan. Approximately 67,000 claims amounting to $13,000,000 have been processed by both Plans for 1978. Administrative charges earned by the Plan are recorded as an offset to operating expenses.

Bonds which are carried at $1,556,000 at December 31, 1978 (market of $1,453,500) were pledged as collateral for a $1,011,960 irrevocable letter of credit issued by a bank to the Department of General Services — State of Florida. The letter is to protect the State in the event of default by the Plans in carrying out their duties under the agreement.

Reimbursements for the administrative cost of services performed for governmental agencies, the State of Florida self-insurance plan and other plans amounted to approximately $20,700,000 and $21,000,000 in 1978 and 1977 respectively, and have been offset against operating expenses. Final determination of reimbursed expenses and claim payments charged to others are subject to audit by the respective agencies.

(7) Employee Pension Plan

The Plan and Blue Cross participate in a noncontributory pension plan for the benefit of all their employees. The pension plan is funded

through the Blue Cross National Retirement Trust, a collective investment trust which serve the retirement programs of its participating employers. Pension expense for the Plan amounted to $1,610,755 and $1,386,440 in 1978 and 1977, respectively. As of the most recent valuation date, the liability for past service costs for both the Plan and Blue Cross was approximately $7,988,000 and the total of pension fund assets exceeded the actuarially computed value of vested benefits.

(8) Supplementary Data

Following is a reconciliation of net income (loss) and unallocated reserve (deficit) on the basis of statutory accounting principles to the amounts reported in the accompanying GAAP financial statements:

	1978	1977
Net income (loss) from operations as reported — statutory basis	$ 8,575,185	(1,231,326)
GAAP adjustment — equity in undistributed earnings (losses) of FCIA	84,864	(80,151)
Net income (loss) — GAAP basis	$ 8,660,049	(1,311,477)
Unallocated reserve as reported — statutory basis	16,076,483	4,753,367
Non-admitted assets principally uncollected premium and miscellaneous account receivable	276,801	167,491
Advance from Blue Cross of Florida, Inc.	(3,000,000)	(6,000,000)
Excess of appraised value of real estate over book value	(5,489,270)	—
Unallocated reserve (deficit) — GAAP basis	$ 7,864,014	(1,079,142)

(9) Rentals under Operating Leases

The Plans lease office space, data processing equipment and automobiles. Rentals are allocated to each Plan based on usage. The leases in effect or committed at December 31, 1978 expire on various dates through 1984. The following is a schedule by years of future minimum rental payments for both the Plan and Blue Cross under operating leases that have initial or remaining noncancellable lease terms in excess of one year as of December 31, 1978:

Year ending December 31,	Basic rental commitments
1979	$2,550,000
1980	2,176,000
1981	1,591,000
1982	1,009,000
1983	809,000
1984	133,000

Accountants' Report

PEAT, MARWICK, MITCHELL & CO.
CERTIFIED PUBLIC ACCOUNTANTS
SUITE 2700 INDEPENDENT SQUARE
ONE INDEPENDENT DRIVE
JACKSONVILLE, FLORIDA 32202

The Board of Directors
Blue Shield of Florida, Inc.:

We have examined the balance sheets of Blue Shield of Florida, Inc. as of December 31, 1978 and 1977 and the related statements of operations and unallocated reserve and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of Blue Shield of Florida, Inc. at December 31, 1978 and 1977 and the results of its operations and the changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Peat, Marwick, Mitchell & Co.

March 12, 1979

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